

DOCUMENT RESUME

ED 327 367

RC 017 957

TITLE Report of the National Action Commission on the Mental Health of Rural Americans. Rural Mental Health: The Time for Action is Now.

INSTITUTION National Mental Health Association, Alexandria, VA.

SPONS AGENCY Pioneer Hi-Bred International, Inc., Des Moines, IA.; Rollin M. Gerstacker Foundation, Midland, MI.

PUB DATE 88

NOTE 40p.

AVAILABLE FROM National Mental Health Association, 1021 Prince St., Alexandria, VA 22314 (Order #-PE-1801 \$9.50 including shipping per copy).

PUB TYPE Reports - Research/Technical (143)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.

DESCRIPTORS Clinics; Mental Health; *Mental Health Clinics; *Mental Health Programs; Qualitative Research; *Rural Areas; Rural Education; Rural Farm Residents; Rural Nonfarm Residents; *Rural Population

ABSTRACT

In the early 1980s, local affiliates of the National Mental Health Association in states with large rural populations began to notice sharp increases in incidences of suicide, family violence, alcohol abuse, depression, and other psychological and emotional problems. These problems may link to negative economic conditions in rural America. In 1987, the National Action Commission on the Mental Health of Rural Americans studied the issue by reviewing the research and data on the incidence and prevalence of psychological and emotional problems in rural America. Based on two hearings held by the Commission, this document describes the social economic changes and related mental health issues in 1980's rural America. The information was analyzed in the context of the existent mental health service system in rural America. A set of recommendations were made for improving access to mental health care for rural Americans and enhancing the quality of services available to this population. Eighteen recommendations are in five categories: (1) legislative and administrative changes for improving service delivery; (2) state-wide planning on funding rural mental health service and the lawful coverage of mental health insurances; (3) public education including training general caregivers and resource people, encouraging mental health service use by reducing the stigma placed on service facilities, and linking rural mental health agencies to school systems to provide information and assistance; (4) increasing funding to expand training and to secure placement of rural professional mental health personnel; and (5) targeting a significant portion of the funds of the National Institute of Mental Health on clinical and service research dealing with rural issues.

(ALL)

* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *

ED327367

PC 017957

Report of the National Action Commission on The Mental Health of Rural Americans

National Mental Health Association

"PERMISSION TO REPRODUCE THIS
MATERIAL IN MICROFICHE ONLY
HAS BEEN GRANTED BY

Preston L. Garrison

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)."

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

☒ This document has been reproduced as
received from the person or organization
originating it.

☐ Minor changes have been made to improve
reproduction quality.

• Points of view or opinions stated in this docu-
ment do not necessarily represent official
OERI position or policy.

Acknowledgments

The National Mental Health Association (NMHA) would like to thank each member of The National Action Commission on the Mental Health of Rural Americans for the unique talent and expertise each member brought to this project.

NMHA is particularly grateful to Bob Bergland, who gave a special distinction to the panel in his capacity as chairman.

The Association would like also to thank Dr. Peter Beeson for the use of his photographs and poetry which have so effectively illustrated this report.

Special thanks from NMHA and the Commission go to Lee Dixon for his authorship of a background document and the research and assembly of reference materials for the commission. The Commission is especially grateful to Mr. Dixon for his efforts and guidance in the development of the final report.

The Commission members thank the participants and witnesses of the regional forums, as well as those who provided written testimony. The report draws heavily on the testimony and materials presented and the interchange of views. However, its contents reflect the views of the Commission and do not necessarily coincide with those of individual consultants.

Many others provided information and guidance to the Commission, including:

Judith and William Heffernan, University of Missouri at Columbia

LwJean Cole, Pioneer Hi-Bred International, Inc.

Michael Benjamin, National Association of Counties

Jane Williams, Office of Rep. William Tauke (R-IA)

Donna Ehrhart, Office of Mental Health Services, State of Iowa

Sheila Navis, Executive Director, Mental Health Association in Iowa

Susan McCullough, Writing Consultant

Wallace Nicoll, Nicoll Associates, Hendersonville, TN

The National Mental Health Association

President—Michael Unhjem

Immediate Past President—Susie Elson

National Executive Director—Preston J. Garrison

Project Director—Anne Carruth

Manager of Communications—Bonnie O'Neill

Media Relations Specialist—Gina White

A special acknowledgment is also due to members of the Mental Health Association family who helped to identify the mental health status of rural Americans as a pressing need and who helped motivate the establishment of the Commission—Susan Crosby, the Mental Health Association of North Dakota and the Mental Health Association in Texas.

The work of the commission was supported by grants from Pioneer Hi-Bred International, Inc. and the Rollin M. Gerstacker Foundation.





Report of the National Action Commission on The Mental Health of Rural Americans

National Mental Health Association



**Report of the
National Action Commission on
The Mental Health of Rural Americans**

National Mental Health Association

**Rural Mental Health:
The Time for Action is Now**



Contents

Commission Membership	4
Preface	6
Rural America in the 1980s	9
Rural Americans and Mental Health	15
Summary Statement of the Commission	24
Recommendations for Action	26
Table of Recommendations	26
Footnotes	34
List of Witnesses	35
Bibliography	36



**National Action Commission
On the Mental Health
Of Rural Americans**

Bob Bergland, Chairman
Executive Vice President
**National Rural Electric Cooperative
Association**
Washington, D.C.



Beeson, Dr. Peter G.
Director of Planning
Department of Public Institutions
State of Nebraska
Lincoln, NE

Benson, Mrs. Naioma
Past President
Women Involved in Farm Economics (W.I.F.E.)
Sterling, CO

Brakke, Mr. Willis J. (Bill)
County Commissioner
Rock County, Minnesota
Luverne, MN

Crosby, Mrs. Susan
Executive Director
Associated Patient Services, Inc.
Indianapolis, IN



Edgerton, Dr. J. Wilbert
 Director of Psychological Services
 Department of Psychiatry
 University of North Carolina
 Chapel Hill, NC

Higgins, Mr. William M.
 Past President
 National Association of Rural Mental Health
 Williamsport, PA

Neal, Delegate Sarah Lee
 Chairman
 Agriculture & Natural Resources Committee
 West Virginia House of Representatives
 Rainelle, WV

Schuetz, The Honorable Bill
 Member
 United States House of Representatives
 Washington, D.C.

Scruggs, Mr. Charles
 Past Editor-In-Chief, Progressive Farmer
 President
 Torado Ranches Inc.
 Austin, TX

Van Hook, Mr. Robert T.
 Executive Director
 National Rural Health Association
 Kansas City, MO

Wichmann, Mr. Robert K.
 Corporate Vice President
 Pioneer Hi-Bred International Inc.
 Tipton, IN



PREFACE

Early in 1984, local affiliates of the National Mental Health Association (NMHA) in states with large rural populations began to notice sharp increases in incidences of suicide, family violence, alcohol abuse, depression and other psychological and emotional problems. Alerted to the research by the National Commission on Unemployment and Mental Health¹ which established a link between negative economic conditions and the rise of reported mental health problems, NMHA affiliates developed programs to address these growing problems.

The Mental Health Association of Texas developed a support group program for families affected by the economic downturn in agriculture and energy products. The Mental Health Association of North Dakota developed hotline information, education materials and a referral service. The Mental Health Association of Indiana developed support groups for farm families. The Eastern Division of Pioneer Hi-Bred International Inc. provided funding to the Mental Health Association of Indiana to start the support group program and utilized the expertise of this NMHA affiliate to educate its 5,000 employees on stress and its impact. By 1985, the work of these state affiliates and others had alerted

NMHA to the need for increased mental health services in rural areas.

In the spring of 1986, NMHA staff and volunteer leadership participated in a policy forum sponsored by the National Institute of Mental Health and the Council of State Governments in Chicago. This forum brought together national, state and local leaders along with representatives from the private sector. It was this Policy Forum on Rural Mental Health which first identified the need for a national commission on the mental health of rural Americans.²

NMHA accepted the challenge to plan, develop, fund and conduct a National Action Commission on the Mental Health of Rural Americans. The Association is grateful to Pioneer Hi-Bred International Inc. and the Gerstacker Foundation provided the necessary financial resources.

NMHA immediately set out to secure the commission leaders from the fields of government, agribusiness, academia, media, health and mental health who had an interest and knowledge of the mental and emotional impact of the events occurring today in rural America. NMHA is indebted to former Secretary of Agriculture



Bob Bergland for chairing this commission. A long and distinguished career as a farmer, member of Congress, Cabinet member and executive vice president of the National Rural Electric Cooperative Association, together with his concern for mental health issues, has made him uniquely qualified to head this commission.

The commission first met in August 1987. Its members brought to that meeting their personal expertise, but quickly realized that they needed to hear from the people who live and work in rural America. Subsequently, on December 2 and 3, 1987, the commission held two separate hearings in Des Moines, IA and Nashville, TN where it heard or received testimony from 37 witnesses representing 14 states. The commission's goal was to review what is occurring in rural America, study the research and data on the incidence and prevalence of psychological and emotional problems in rural America, and listen to the people of rural America to better understand their mental health service needs.

The commission has analyzed this information in the context of the current mental health service system in rural America and has developed a set of recommen-

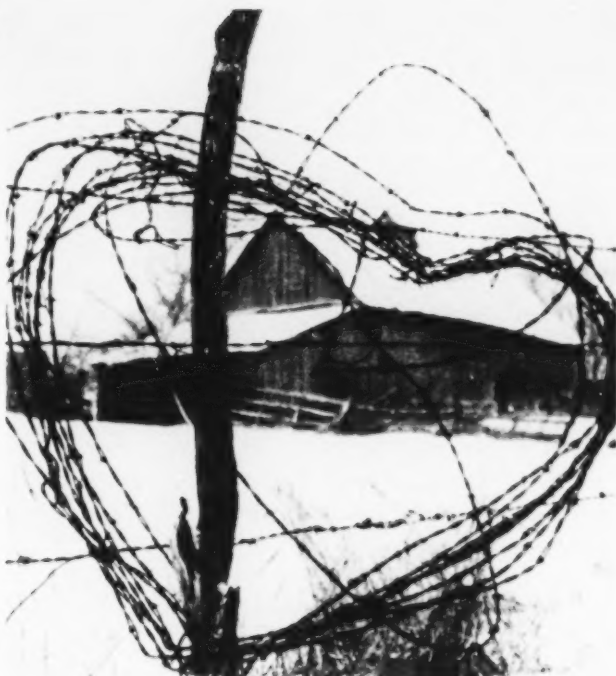
dations and action steps. These recommendations and accompanying actions are aimed at federal, state and local government leaders as well as the private sector across a range of program needs. Mindful of economic constraints, the commission sought to develop recommendations and actions that were rooted in commitment, change, understanding and networking. This is not simply a cry for more money, though the commission realizes that rural America generally has not received its fair share of funding for health, mental health and human services.

This report is directed toward the future leaders and policy makers of our country at federal, state, and local levels. Those policy makers will take rural America from the difficult times of the 1980s and lead it into the 1990s and will have the opportunity to make a positive difference for the people who live there. We wish to place this report in their hands as a basis for the creation of a realistic plan of action for the 60 million people who make up rural America.

SO IT GOES

A dusting of snow
Highlights deep green winter wheat
A bow of bright yellow leaves
Frames a fading blue sky
Tall white sentinels stuffed of unwanted grain
Stand guard over rusty ribbons of steel
While bare trees cast afternoon shadows
Over faded seed and feed signs
Streets turn to gravel then dirt
Running away into the sunset
Marking off unplowed fields
Assets of a bank gone under
Grain dust and road dirt
Share the air
With the silence of
Boarded school windows and abandoned swing sets
Homes, gray and worn
Mostly empty
Recede
Shrinking from bright red 'For Sale' signs
A tattered gray cat
Wanders from porch to porch
A left-behind mouser
Now a ghostly town crier
The church steeple's black shadow
Creeps down mainstreet
Running back to peeling white paint
And dust laden pews
Like cattle at a feed trough
Mud splattered pick-ups line the curb
Staring into dark storefronts
Empty reminders of better days and lost friends
The only sounds are the rustling of leaves on old brick streets
And the faint talk of weather drifting from the tavern
Where gray stubbled faces with weather worn eyes
Blankly search the Hamm's beer sign
Rolled up coveralls
Hover over old scuffed boots
That shift with discomfort
At the mention of foreclosure
In each other they see
Survivors or hangers on
Not sure which
They share the passing of a way of life

Peter G. Beeson





RURAL AMERICA IN THE 1980s

The 1980s have been difficult for rural Americans. The lives of countless men, women and children living in rural communities across the United States have been stressed by rapidly changing social and economic realities. Today, financial hardship is the norm in the farming, petroleum, mining, lumber and textile industries of rural America. Poor and inadequate health care systems are common in many rural communities. An ever-eroding tax base is resulting in underfunded public schools and human service programs. All these factors are contributing to the declining quality of family and community life in rural America.

Senate Agriculture Committee Chairman Patrick Leahy (D-VT), in a June 1986 Washington Post article stated, "Rural America is hurting. Through the 1980s, the changing global marketplace closed the door on economic growth across rural America. Small manufacturing plants succumbed to foreign competition. Farms and farmers disappeared. Oil wells stopped pumping and mines closed."³

The statistics show that:

1. In 1979, 5 percent of the 2,040 non-metropolitan counties in the U.S. had high unemployment



(unemployment rates of 9 percent or more of the civilian labor force), but by 1984 that percentage had risen to nearly 50 percent. By 1985, an additional 100 non-metropolitan counties had unemployment rates in excess of 9 percent.

This does not include people who have lost their farms.⁴ In addition, 35 percent of the workers in rural America are underemployed and have to take a part-time job as the sole provider for the family. Thus, nearly half of the work force in rural America has either no job or an inadequate job.

2. Official unemployment statistics typically underestimate the unemployed in rural areas, according to the U.S. Department of Agriculture's Economic Research Service. Because of undercounting the number of workers forced into part-time employment because full-time work is not available, rural areas are not receiving their fair share of funds to combat unemployment. In addition, the statistics do not reflect the degree to which individuals are working for low wages.

3. Between 1981 and 1983, rural America lost 500,000 jobs.⁵

4. Sales of tractors, combines and harvesters by farm implement and equipment industry plummeted from 305,000 units in 1979 to 146,000 in 1986.⁶

5. International Harvester Company went through bankruptcy, reorganized and no longer manufactures farm equipment. Massey-Ferguson has restructured. Deere & Company lost \$331 million during a six-month period of 1986. The Allis-Chalmers Corporation filed for bankruptcy in June 1987.⁷

6. Twenty-five percent of the U.S. population lives in rural areas, but 38 percent of the people who live in poverty, live in rural areas; 67 percent of the nation's substandard housing is found in rural areas; and the unemployment rate is 50 percent higher in rural areas.⁸

7. Federal funds going to rural America (other than commodity subsidies) have declined 40 percent since 1981.⁹



The farm, oil, lumbering and small manufacturing crises of the early and mid-1980s are far from over. From all indications Rural America will continue to undergo profound economic, social and political change, forever altering the idyllic picture most Americans once had of Norman Rockwell's peaceful and inviting rural landscape. The transitions which miners, lumbermen, drillers, farmers, small business people, teachers, physicians and bankers and their families have experienced are continuing.

The rural American economy is uniquely dependent on commodities; commodities that are controlled by worldwide decisions and pressures. For instance, as long as the global price for oil remains at a low \$19 per barrel, other oil-producing countries of the world realize that exploration for oil in Texas, Oklahoma and elsewhere in the United States will stay at a minimum level.

The farm situation is only part of the rural picture. Economic problems in the rural South, which is the nation's most predominantly rural region, threaten to be a permanent drag on the general prosperity and development of the Sunbelt, according to a group of economic experts.¹⁰ Manufacturers who were drawn to the South decades ago because of cheap labor now have found still cheaper labor in Asia.

Rural economies no longer depend on agriculture as they once did, according to a recent report by the U.S. Department of Agriculture (USDA). In fact, there are now more rural jobs in manufacturing and services than there are in agriculture. Although farm foreclosures and the 1988 drought have captured the headlines, much of the rural economic decline in America can be attributed to the 1982 recession, increased foreign competition and macroeconomic forces that affected non-farm industries.¹¹

While some people indicate that current conditions in the rural American economy are likely to continue for three to five years, others believe they will be more long-lasting and more far-reaching in their effects than is generally realized. No matter which scenario one selects, it is a fact that the term "crisis" is misleading. Crisis implies a short-term phenomenon. Rural America has gone from a state of crisis to becoming a chronic economic, social and health problem area.

The effect of rural America's decline on governments, education and health care has been disturbing. State, county and local revenues which support human services, education, health and mental health programs in rural areas have been severely eroded by the precipitous drop in land values that have occurred. Although



land values recently have stabilized, and in a few areas actually have increased, the overall picture is one of an eroded base.

Property taxes are the primary means of support for county services. Thus, the drop in land values along with the delinquency rate in tax payment has seriously curtailed county programs, according to a report by Sen. David Durenberger (R-MN) of the Senate Subcommittee on Intergovernmental Affairs in 1986. Concurrently, Congress eliminated the General Revenue Sharing program in 1986, further restricting the resources available to rural America.

Consequently, local governments in rural areas have become increasingly dependent upon state financing to maintain critical public services. But state treasuries have not been able to help substantially, if at all, especially in oil producing states. Iowa State University Professor Neil Hari foresees changes in the scale of health care in rural areas, the range of services provided and the willingness or ability of local government to furnish those services.¹²

Janet Fitchen of Ithaca College has stated, "... the current farm problem is part of the prolonged period of change in the structure and technology of producing food and fiber. It affects all sectors of American agricul-

ture, and reflects major shifts in global as well as domestic food production and marketing. Both the current and the long-term economic adjustments in agriculture will have major and far-reaching social impacts on rural America."¹³ This statement can also refer to the changes in mining, textile manufacturing and lumbering in those sections of rural America where they dominate the economy.

No matter which section of the country, effects of the economic situation quickly reach the family. The effect of financial or economic stress (whether it is unemployment, unpaid loans or insolvency) on a rural family's standard of living shows up quickly. Health insurance is cancelled; regular medical check-ups during a pregnancy are cancelled; home repairs are put off in favor of car or truck repairs; new clothes for the children are put off in favor of "hand-me-downs"; and even school is put off because of a lack of boots or proper clothing during the winter.

The husband and/or wife may seek a part-time or off-the-farm job. USDA reports that about two-thirds of farm families have off-farm income, and 60 percent of the net income to farm families comes from off-farm employment. Quite often the typical off-farm employment is a maintenance or cleaning job at the local or



nearby interstate highway motel. However, even this source of income will decline or even disappear as investment in rural America declines.

Certainly the economic decline of rural America has been well chronicled over the past few decades, as the United States has become increasingly urbanized and its economic base has shifted. Though it is beyond the scope of this commission, there is a need to address the economic situation in rural America. Properly addressing economic issues vital to rural America will go a long way toward assisting and correcting the problems on which the commission heard testimony during the two days of hearings.

In her book *Poverty in Rural America: A Case Study*, Janet Fitchen has chronicled how rural people have been unable to prevent the eventual social and leadership disintegration of the small community. The blight that initially afflicted and struck at the economic base of one sector of rural America eventually eroded its leadership capabilities. Without leadership, no economic development or redevelopment initiative will be successful.¹⁴

In summary, the 1980s have seen the beginning of a restructuring of rural America similar to the massive changes that followed the 1930 depression and those

that occurred during the industrial revolution in this country. Great social and economic forces are drastically changing today's rural environment. In many ways this change represents a literal shrinking of population, businesses, services (schools, churches, health care, human services, mental health care, etc.), economic base, tax base and employment opportunities.

There is a tremendous human cost to this restructuring. While it has been labeled a crisis—which has short-term implications—the effects of this problem are long-lasting. Rural America has never been the idyllic environment that most Americans picture. There has always been greater poverty, illiteracy, suicide and other social problems in rural areas than in non-rural areas. These chronic social problems, coupled with a lack of access to health and human services, have made mental health problems an issue for rural Americans long before the "rural crisis" occurred. The rural crisis of today and the subsequent restructuring of rural society are contributing to a different tomorrow, and have thrown a spotlight on the enduring mental health problems of rural America.

AGAINST THE GRAIN

Turning off asphalt
My car stirs up dust
A pheasant
Freedom
Wheels slide in gravel
Settle into grooves
Crooked posts linked by drooping threads of rust
Grow closer and closer together
The road runs west
Sliding under puffy clouds
That spill over the horizon
And cast dark shadows over the land
Broken sunlight
Racing in irregular patches
Ripples over hills and fields
Running away from the coming storm
A caved in barn
Bent windmill
And weed covered junk pile
Hint of farm troubles of yesteryear
An old brick schoolhouse
Boarded windows and broken swings
Tell tales of consolidation
And moves to town
A hump in the road
Reveals an abandoned railroad bed
Ties and rails
Long since salvaged
An old couple
In matching coveralls
Harvest aluminum can litter
In roadside ditches
To my right a solitary cemetery
Fields ploughed to its edge
No church, no congregation
No one to bury
Then the road ends
A barricade, "Bridge Out"
Another failing
Awaiting better times
I turn south
Skirting the creek
With its cottonwood canopy
And winding, steep clay banks
In the shadow of an old tin elevator
The road turns to blacktop
Old boxy frame houses
Sprout from little square lots
Mainstreet buildings wear signs of the times
A Bank turned Post Office
A Western Auto turned Senior Center
A farm implement dealership turned vacant lot
Churches with peeling paint
Homes in disrepair
An invisible pathos
Seeps from everywhere
At the center of town
Cobblestone emerges from a sea of crumbling concrete
And runs north to a weed covered baseball diamond
Sporting a weathered sign, "Nebraska the Good
Life"



Splat
A big raindrop
Then another and another
Dot the windshield
Small clear portholes
Appear in a film of road dust
Then give way to a watery blurr
As if my eyes had filled with tears
Before I know it, I hit gravel again
Am reunited with fields of harvested corn and milo
Flanked again by barbed wire railings
I head on under a darker sky

Peter G. Beeson



RURAL AMERICANS AND MENTAL HEALTH

The economic problems and social changes occurring in rural America have serious emotional and psychological impacts on the people who live there. The psychological and interpersonal problems of many rural Americans, some of which are truly tragic and dramatic, initially caught the attention of the national news media and motion picture industry in 1985 and 1986. While these events and the resulting psychological disabilities which many rural people suffer no longer capture newspaper headlines or box office sales, their occurrence and seriousness have not declined. Those familiar with rural America continue to indicate that these events are just the tip of the iceberg.

Too often, the isolated case of one individual who is taking unfair advantage of the U.S. crop subsidy programs receives wide notoriety and erases the conce

that should be focused on the young and the elderly of rural America—concern for their mental health and the high risk they run for developing serious emotional and psychiatric disabilities.

In 1977, the President's Commission on Mental Health first pointed out that there was a lack of data and research on rural mental health. More than 10 years later, that statement is still true; but information which does exist is poignant and disturbing.¹⁵

In North Carolina, Dan Blazer, M.D., (Duke University, 1985) reported on the results of a rural/urban comparison of psychopathology from the Piedmont region of North Carolina. Using a household survey questionnaire developed by the National Institute of Mental Health for its Epidemiological Catchment Area study of the incidence and prevalence of mental illnesses, 3,921

adults were interviewed. The research investigators found significantly higher rates of alcohol abuse and/or dependence and of cognitive deficit problems in rural areas as opposed to urban areas.¹⁶

In Minnesota, Barry Garlinckel, M.D., and Harry Hoberman, Ph.D. (University of Minnesota, School of Medicine, Department of Psychiatry, 1986) reported the results of a study of 4,300 adolescents in three communities in rural Minnesota. The teenagers, age 15-19, came from farm and non-farm rural community families. Of the 2,200 adolescents surveyed in the first community, three out of every 100 had attempted suicide in the last month, and the incidence of depression among them was twice the national average.

More specifically:

- ☐ three out of every 100 attempted suicide in the last month. This is 15 times more frequent than the national average which is two out of every 1,000.
- ☐ 72 percent of the suicide attempts were young women.
- ☐ 80 percent of the suicide completions were by young men.
- ☐ 88 percent of those who attempted suicide were clinically depressed.

Both the incidence and severity of depression among the 4,300 adolescents were measured in several different ways. In a self-report, 34 percent reported being depressed within the last month, 35 percent reported being depressed in the last six months. Perhaps the most startling piece of data was that when these adolescents were given the standard Beck Depression Test, 18 percent were determined to be moderately or severely depressed. This 18 percent is more than double the percentage of adolescents reported to be moderately or severely depressed in a similar study conducted in New York State. Of even more concern was the fact that, on average, these depressed adolescents living at home had a score on the Beck Depression Test greater than that for the adolescents hospitalized at the University of California at Los Angeles (UCLA) Neuropsychiatric Institute at the same time.¹⁷

In Missouri, a study by William Heffernan, Ph.D., and Judith Heffernan (University of Missouri at Columbia, 1985) reported on 42 farm families in one of Missouri's top agricultural counties. These families had all been forced out of farming. They tended to be young and had an average of three children. It is significant that all of the women and all but one of the men indicated that they had experienced depression at some point during the process of exiting farming. More than half of the men and three-quarters of the women continued to experience depression one year after losing the farm. Almost two-thirds of the men and women became withdrawn from family members and friends. Increased substance abuse (mostly alcohol) was reported. Half of the men and one-third of the women reported that they had become more physically aggressive toward family members.¹⁸

A study of 50 community mental health centers in 12 midwestern states by Joanne Mermelstein and Paul Sundet, Ph.D. (University of Missouri at Columbia,



1986) reported that almost two-thirds of the centers had experienced a moderate to very large increase in dysfunctioning among their client populations. Twenty to 50 percent of the rural mental health clinicians' caseloads were people suffering from problems related to the agricultural economy. The ranking of mental health problems, as seen by the clinicians, in these 50 centers was: 1) depression, 2) withdrawal/denial, 3) crisis behaviors, 4) substance abuse and 5) spouse abuse.¹⁹

In Colorado, a 1986 survey of factors associated with admissions to mental health centers in rural and urban Colorado counties by the Colorado Department of Mental Health observed that:

- ☐ Child abuse cases had increased more rapidly in rural community mental health centers than in urban centers.
- ☐ Spouse abuse had a slightly higher incidence in rural community mental health centers than in urban centers.
- ☐ Alcohol abuse had increased in both urban and rural areas, but in rural community mental health centers, alcohol abuse had increased from a lower incidence to a level of incidence



equal to urban areas, most notably for adolescents.

- Child/adolescent depression admissions to rural community mental health centers had almost doubled.
- Depression and anxiety disorders had increased in rural community mental health centers, in contrast to urban areas.²⁰

In Nebraska, a study by Peter Beeson, Ph.D., and David Johnson (Nebraska Department of Public Institutions and University of Nebraska, 1987) reported that residents of farm households went from having among the lowest rates of psychological distress in 1981 to among the highest in 1986.

Results of the study indicated that in 1981 when farmland values peaked, the greatest percent of respondents with depression were found among the large urban and urban area residents, with farmers and rural residents having the lowest rates. By 1986, the highest rates for depression were among the farmers and rural segments of the sample, with the lowest rates in the urban and large urban areas. In fact, from 1981 to 1986 the percentage of farmers experiencing symptoms of depression doubled.

In all except the large urban areas, the incidence of depression increased. The increase in depression was greatest among residents of farm households, followed by progressively lesser increases in the rural and the smaller urban areas.

Of the farmers reporting high economic distress, 28 percent also reported symptoms of depression, compared to 12 percent of the farmers reporting low economic distress. Farmers also had the greatest increase in psychosocial dysfunction.

The study also revealed that, even when not personally affected by economic decline in their own household, those most closely linked to the agricultural economy were significantly more likely to be depressed, have more psychosocial dysfunction and greater psychopathology than those in the large urban areas.²¹

Building on these research data were the two days of hearings that the commission conducted on December 2 and 3, 1987. A total of 37 witnesses from 14 states provided testimony on the conditions of rural Americans. (See Appendix for list of witnesses.) Their vivid presentations to the commission assured the commissioners of the pervasiveness and depth of the problems.

Hearing in Des Moines, IA, December 2, 1987

Norma Harms testified before the commission as a farmwife. Harms and her family have endured many hardships, some of them directly related to the crisis they experienced with their own farm, and others directly related to the tragedy of mental illnesses. In her testimony, Harms stated that a 1984 University of Nebraska study projects that by 1990 all towns in Nebraska of less than 900 people will disappear. She went on to cite U.S. Department of Labor statistics which show that at least three jobs are lost every time a farm is liquidated, and that one business fails in rural America for every 10 farms that are sold.

Harms' home town of Hartington, NE once had a satellite mental health clinic. But because of the economics and the stigma of mental illnesses, which led to a low utilization rate, it was closed in 1981. With the abandonment of the satellite clinic, the closest mental health facility is 35 miles away in Yankton, SD.

Harms told of how school officials in her local school district were alarmed at the number of reported incidents involving mental, physical and sexual abuse. Two of Harms' sons, both deceased, refused to seek help from the health or mental health system because they claimed their brother, who was institutionalized, wasn't being helped by that system. Despite these experiences, Harms sought the assistance of the mental health system available to her, when she needed attention and treatment. Hospitalized for 29 days for depression, she returned home only to find that her health insurance policy would not pay for her illness.

Myrt Armstrong, Executive Director of the Mental Health Association of North Dakota, began her testimony in a most poignant manner, trying to sort through the many facts she had stored in her mind that would be useful and important to the commission and its work. But as she said, "Facts aren't very useful to me at 2:00 in the morning, as I talk with a panic-

stricken farm woman whose husband has just grabbed the shotgun from the gun closet and left for the barn in a depressed rage. And yet, I realize that the many stories of pain, turmoil and survival which flood my mind when I think about farm families these days must be put in some type of context. Otherwise, they can be too easily dismissed as a few tragic, but isolated examples of personal tragedy. They are, in fact, much more than that."

The North Dakota Department of Human Services documented an increase of more than 300 percent in reported cases of domestic violence; from 950 cases in 1980 to 3,450 cases in 1986. Reported cases of child abuse almost doubled from 1,685 in 1980 to 3,021 in 1986. Death by suicide, which is an under-reported statistic, rose from 73 cases in 1980 to 93 in 1985. In one rural county, 11 suicide attempts were reported within two months. The North Dakota Department of Human Services also reported that rural mental health facilities cited depression as the number-one mental health problem with which they were having to deal.

Armstrong pointed out that understanding the American work ethic, and its apparent failure in rural America, is crucial to understanding the frustrations of rural Americans. Today, instead of being rewarded for hard work, rural people are finding themselves unable to succeed no matter how hard they try. In desperation, the farmer or miner has looked for someone to blame. Armstrong recalled Henry Fonda in the Depression era movie "Grapes of Wrath," when he demands to know, "Who do I shoot?"

During her testimony, Armstrong related the story of a young farmer operating a third-generation farm who needed financial help. His father signed the bank note to help him. But when the crop failed, they both lost everything. This father and son also had some registered quarter horses, and when the young man learned that they too would be lost, he informed everyone he would kill anyone who set foot on his land to take his horses. This man, who had served two tours of duty in Vietnam and faced losing his grandfather's farm, had reached his limit. If he had to lose it all, then he would take everyone with him.

Another farmer reacted in a totally different, but no less distressing manner. Instead of lashing out he literally hid from the world, by not answering the door and even hiding in the back of his pickup truck when someone would drive onto his farm. His fear of losing the farm had turned to paranoia. This previously hard-working person had been reduced to a frightened shell of a man.

Joanne Mermelstein and Paul Sundet from the University of Missouri's Department of Rural Sociology reported to the commission on data from their most recent studies. Mental health clinicians in a 12-state study indicated that between 20 and 50 percent of their caseloads were people suffering directly from economic problems. The rank order of problems was depression, withdrawal-denial, crisis behaviors, alcohol abuse, spouse abuse and psychosomatic disorders. Of the clientele, 38 percent were 30-39 years of age. Tragically, however, 7 percent of the clinicians reported that the majority of their clients were between 60-69 years old, a fact that probably reflected the situation of aging

parents who lost the accumulated assets of a lifetime by helping a son or daughter. The issue of the elderly in rural America is a critical one.

A unique aspect of Mermelstein and Sundet's research is their attempt to see the effect on communities and community leadership. They reported that in a survey of 104 county and community leaders in a 5-county area, 93 percent of these leaders believed that everyone, or almost everyone, in the rural community is suffering. Over 75 percent of these leaders believed the community was declining or already dead. The reasons given by these community leaders for their own or others' lack of attempts to revitalize the communities were very revealing. Sixteen percent said that people are too depressed by the situation they are presented with to do anything about it. An additional 20 percent reported that many people have given up already.

Mermelstein and Sundet concluded that the classic concept of anomie is an apt characterization of the current tenor of rural America. The optimism that has sustained farm communities in the past is rapidly eroding and a substantial portion of the leadership has reached such a state of depression that many individuals normally identified as indigenous agents of change, initiative, and energy are immobilized. The overall climate of emotional depression is pervasive and growing.

Sundet and Mermelstein next reported on their study of 118 rural community mental health centers in 12 states. They found that 61 percent of the mental health directors reported a severe or very severe economic crisis in their locales, with another 27 percent describing a moderate level of distress. They then were asked to rate their level of effort regarding eight programs that would directly relate to the services required by such a situation. Those programs were: 1) a telephone hotline; 2) consultation and education; 3) rural development; 4) media programs; 5) support groups facilitated by center staff; 6) crisis intervention; 7) integrating multi-agency services, and; 8) stimulating the formation of self-help groups.

Of the eight program options, a majority of the directors indicated they had made no effort whatsoever for three of them. More than 40 percent of the directors had not expended any effort on two others. The most popular program was consultation and education, but it mustered a score indicative of just "some effort" to mount such a program. Less than 30 percent indicated any efforts to develop crisis intervention that were at or above a moderate level. Less than 25 percent of the mental health directors tried to gain from the experiences of others. The center directors said they lacked the funds necessary to even contemplate starting any of these programs.

Sundet and Mermelstein state that starting approximately 10 years ago, there has been a steady shift in fiscal support away from community-based programming, first at the federal level and then at the state level. This is partly due to a lower overall level of community mental health funds and partly from a drive for greater accountability. It is also the result of the greater responsibility given to local mental health centers for caring for the deinstitutionalized population.

Billable therapy sessions, third-party and direct-fee payments and purchase-of-service contracts have become primary, and frequently exclusive, sources of funds for rural community mental health centers. Federal and state support for community education, consultation and even vital outreach programs has all but disappeared in some areas. Directors who have maintained these services have frequently done so with highly creative funding schemes, or as one rural center director stated to Mermelstein and Sundet, "We take it out of our hide. We do the extra work around here because it has to be done."

One of the key witnesses heard by the commission was Nedalyn Testolin, a rancher and founder of the Wyoming Rural Support Group. Wyoming's farm and ranch, oil, gas and coal industries have all gone through difficult times. The Wyoming Rural Support Group has provided assistance to approximately one out of every 10 families in Wyoming.

As Testolin said, "... imagine, if you can, what it feels like to be losing ranches or businesses that have been three, four, five generations in the making. Reflect on the personal desperation and then try to remember that requesting assistance is seen as that last measure of defeat, since we have long measured accomplishment in terms of private enterprise and private problem-solving. We continue to believe we must sustain that individual approach in any turmoil or tragedy rather than draw upon any outside strength, especially assistance from human service programs since we are very skeptical of any agency or bureaucracy.

"... we are not people who are going to go into mental health centers and fill out forms. We are not people who think of food stamps as an option, of low-income energy programs or public health care provisions.

"... what happens to us when we cannot or will not avail ourselves of any of these avenues? Hopelessness and helplessness develop and make for a depression that fosters child and spouse abuse, separation and divorce, alcohol and other drug addiction, violence and suicide."

How do we reach rural Americans who have such values and traditions? Testolin said, "We must initially reach them through means which they deem acceptable. The acquisition of knowledge is acceptable in rural America. The acquisition of financial, legal and certainly educational information is considered a worthy goal." So we must, in her words, integrate into our various community systems the opportunity for gaining access to mental health services.

In her testimony before the commission Testolin went on to advocate for the identification and training of mental health professionals who become a part of an aggressive outreach effort. She felt that leaders must be sought who can become liaisons with rural people.

However, such programs cannot depend entirely on volunteers or lay people; delivery of therapeutic treatment requires skill and formal training. Alliances among the National Institute of Mental Health, Department of Agriculture, the Department of Labor, human service providers, educational institutions and any other source who in turn can create preventive programs must be developed.

Testolin went on to discuss how mental health professionals must be encouraged to assume higher profiles in their communities and undertake more civic responsibilities. They should open their buildings to the community for public use for non-medical purposes. They should foster the wide use of meeting room facilities so rural people feel more comfortable and familiar with these facilities. Clinicians must be taught to get out of their offices.

Dr. Max Glenn testified on behalf of the Oklahoma Conference of Churches. A farmer, minister and long-time rural advocate, Glenn is also coordinator and director of Ag-Link Coalition, a farmer/rancher-controlled crisis hot line that receives 60 calls on a typical day. The hot line links callers to existing human service agencies through channels acceptable to members of the rural community who use the line.

The economic downturn in agriculture and energy production in Oklahoma, according to Glenn, has produced a series of events that include: 1) 68 banks closing in the past six years (32 of them in 1987 alone); 2) \$1 billion of farm, commercial and personal loans in the hands of the Federal Deposit Insurance Corporation; 3) 105 suicides in rural Oklahoma; 4) a 300 percent increase in one judge's juvenile caseload; and 5) a 143 percent increase in the number of farmers seeking treatment for alcohol abuse.



In discussing the public mental health system's response to the need for increased services, Glenn was particularly distressed by its urban bias. Too often the response was to set up an appointment in the future and have the person come into the office.

The Ag-Link Coalition's hot line and accompanying support group intervention has led to the development of working relationships among county commissioners, farmers, the county sheriffs and county mental health professionals. Frequently, however, it is the county mental health professionals who are often not available.

In response to this void, Ag-link's network of volunteers are learning basic helping skills so that they can effectively aid those in acute distress. However, the lack of access to a readily available mental health system makes referral for long-term treatment difficult.

Glenn recommended that mental health services be part of any rural revitalization and development effort. Specifically he advocated grass-roots mental health programs that link crisis hot lines and mental health services. Perhaps most important, he felt there must be a strong emphasis on training mental health professionals and other helping professionals to be sensitive to the unique culture of rural areas.

Hearing in Nashville, TN, December 3, 1987

At its forum in Nashville, TN, the commission heard from Elsie Allen Byrd, president of her local Mental Health Association. She praised the work of the Florence County Mental Health Center and its satellite clinic in Hartsville, SC, but felt their service to the rural population fell short because the clinicians and staff knew nothing about the traditions, way of life or perspective of rural Americans. Byrd said she was not criticizing their formal training or their skills, but felt that without knowing about personal characteristics common to rural Americans, these professionals could not effectively serve in rural communities.

The research findings of the Garfinkel and Hoberman study are some of the few which focus on rural adolescents. The commission felt it was vital to have Harry Hoberman, Ph.D. testify before the commission to reveal the subsequent research findings developed in the past 18 months.

More recent studies of predominantly rural adolescents have shown continuing high rates of depression and suicide attempts. While the previous research had been an anonymous study, the new project asked the adolescents to identify themselves. When adolescents in the study developed a score that indicated depression or suicidal tendencies, the information was referred back to the school so that appropriate intervention was possible.

Because of a request that the students in this study identify themselves, the rate of depression and suicidal behavior from the previous study was cut in half. In spite of this, the rates remained significantly high. In addition the more recent study revealed relatively high rates of physical and sexual abuse, alcohol and drug abuse and eating and weight pathology. The new rates were generally comparable to those reported for urban adolescents.

Hoberman specifically detailed the impairing nature of depression. There is, as he said, a strong tendency



in our society to trivialize the occurrence of depression and its effect on a person's life. But depression has a significant effect on a person's motivation and ability to commit to a plan of action. Particularly in adolescents, depression impairs the ability to concentrate. When comparing the depression symptomology of adolescents and adults, adolescents are much more likely to have impaired concentration and difficulty in problem-solving. These characteristics of adolescent depression have a great impact on school performance. We also know that depression in adolescents and children significantly impairs family and peer interactions.

The critical point to consider here is that this impairment of concentration, problem-solving, family and peer interaction and school performance comes during one of the most important times in a young person's development. Young people suffering from depression are therefore prevented from reaching their true potential. They then become a drain on the social service system through delinquency, teenage pregnancy or unemployment.

Hoberman reported from the most recent study that 20 percent of the rural youth questioned described themselves as sad, dissatisfied and depressed. Two percent of the males and 6 percent of the females



reported they had made a suicide attempt in the past year. Four percent of the males and 8 percent of the females said that they had made a suicide attempt at some point in their life.

Hoberman explained that because most suicide attempts are generally not completed, there is a tendency to believe the psychopathology that characterizes these people is minimal. However, studies have shown that adolescents who attempt suicide do so repeatedly.

Hoberman went on to state that 4 percent of the males and 12 percent of the females reported being physically abused. Two percent of the males and 13 percent of the females reported some kind of sexual abuse.

Alcohol abuse is also a factor. A third of these rural young people drank either beer or wine in the last month; 20 percent drank hard liquor. A third reported that they, at least occasionally, consumed large quantities of alcohol and then drove an automobile. This exceeds the current urban statistic.

FARMSTEAD

Roller coastering, my old truck and I roam ribbons of gravel that gift wrap, civilize, these open spaces. "Go West Young Man, Go West!" "As Far As The Eye Can See!" "Westward Ho!" Waves of golden wheat brush against big blue sky. Shadows of weathered fence posts stretch eastward falling away from the yellow-white glare of the west. Orange streaks, followed by brush strokes of red, arc across the blue canopy. Even the rusting stock tanks and bullet riddled signs take on a warm glow. The earth heaves a quiet sigh and fades to purple under a cooling dusk. Horizons that earlier seemed to mark the ends of the earth blur with the sky, sweeping the world into a shrinking bubble. A broken windmill, empty silos, tilting barn, and vacant house become a cluster of sentinels peering into the coming darkness, moaning with a wind whistled silence, calling to the past. Tugging at the soul they drag us to a halt and beckon the mind to wander among their shadows. The weed strewn lane aches for familiar footsteps. The old tire swing longs for the trappings of children. Rooms, empty and cold, mourn the loss of warmth and laughter. What happened here? Farmer's folly? Poor public policy? Dustbowl? There are no clues, only the blank stares of broken windows and the whispered eulogy of rustling leaves. Slowly the shadows become lost to the shroud of night and the mind grows wings. Curiosity gives way to fear and ghosts dance in the rearview mirror.

Peter G. Beeson



The Imbalance of Mental Health Service to Rural America

The data and testimony presented to the commission during the course of its three meetings indicate that the symptomology of serious mental health problems in rural areas is increasing at a rate that parallels or exceeds urban areas. In addition, people both directly and indirectly affected by the restructuring of the rural economy are suffering emotional and psychological disabilities.

While the data, to this point, have not indicated an increase in such disorders as schizophrenia or dementia, the illnesses and problems described are truly debilitating. While hospitalization may not be required, a declining mental health status nevertheless causes people to become dysfunctional and leads to the development of serious disorders such as prolonged depression. In some cases, most clearly pointed out by the studies in Minnesota, this depression can lead to a serious psychiatric disability, especially in view of the data from the Beck Depression Test that was given to rural adolescents.

At the same time that more rural people are suffering serious mental health problems, the system of mental health services to care for them shows signs of serious impairment. This is not a new development. In 1969, the federal publication *Mental Health Services for All Americans: The Challenge of Rural Mental Health* showed the degree to which rural mental health services were deficient. It noted that only 1 in 14 rural counties had a general hospital with a psychiatric facility, compared with 1 in 3 in urban centers. Only 10 percent of outpatient psychiatric clinics were in rural areas and many of those were part-time. A 1965 survey found that only 3 percent of the psychiatrists in the United States reported their place of employment as a rural county.

The implementation of the Community Mental Health Centers Act of 1963 held great promise to correct the imbalance for rural America. Between July 1965, when the first grant under the Act was awarded, and June 1973 more than 500 community mental health centers (CMHCs) were funded. Approximately 40 percent of these served catchment areas (geographical areas of approximately 250,000 people) with one or more rural counties. However, when rural counties having access to a central city were excluded the number was considerably smaller. Only 76 of those 500, or 13 percent served all-rural catchment areas.

In 1981, the last year of the Community Mental Health Centers Act, it was found that only 97 of the 768 CMHCs served all-rural catchment areas,— less than 13 percent. As the CMHC program expanded, the proportion of centers serving all-rural catchment areas remained static. The promise of correcting the imbalance of mental health services to rural America was unfulfilled.

Whether this imbalance would have been corrected became a moot point in 1981. One of the early pieces of legislation in the Reagan Administration was the Omnibus Reconciliation Act of 1981-P.L. 97-35. Under the philosophy of less government, it repealed the Mental Health Systems Act and in its place enacted the Alcohol, Drug Abuse and Mental Health Services Block Grant. While espousing the same principles of community mental health, the block grant was used to cut federal support for mental health services. In 1980, \$314 million was appropriated by the Congress for the operation of federally-initiated community mental health centers. That plummeted to \$204 million in 1982 under the block grant and has risen to only \$238 million in

1988. A "normal" rate of inflation of 5 percent would project the 1980 figure to be \$463 million in 1988.

How have mental health services fared over the past few years under the block grant? A few studies have been done, but perhaps the most revealing, concerning rural mental health services, was done by Ahr and Holcomb in 1985.²² They surveyed the priorities of the 50 state mental health directors and found that services for the severely disordered were ranked highest. The next-to-lowest ranking—62 out of 63—was given to developing a model of community mental health center services in rural areas.

Myth versus Reality in Rural America

As we have seen from the data and the testimony, there are many false assumptions about rural America which need to be corrected. The myth of a close-knit community and family structure needs to be dispelled. It should no longer be assumed that everyone in a typical rural community knows each other. The accepting of a second and sometimes third job at distances far from home does not permit time for neighborly visiting or even attendance at civic or church gatherings. While one's word or a handshake were once accepted as a commitment, now only a contract is accepted.

Churches are no longer the primary focus or link to people that they once were. In fact, many church organizations place new pastors or priests in rural areas who do not understand the nature of rural America. Concurrently, these new clergy tend to use a rural assignment as a springboard to better assignments elsewhere and therefore concentrate their attention on church members who are large contributors. Researchers have found that churches were one of the least used resources during a time of crisis.

The commission has seen that the stigma of mental or emotional problems is as strong as ever among rural Americans. Rural Americans often are individualistic in style, self-reliant in their approach and tend to hide their problems. The display of strong emotion is equated with irrationality and weakness. There is a reluctance to view counseling and/or therapy in a positive light.

As noted earlier, two-thirds of all farm families have off-the-farm employment. This usually means women (wives) taking off-farm jobs to make up for the loss of income, to help repay loans or sometimes to become the sole income provider. This situation repeats itself with the families of the unemployed miner, lumberman, oil driller or textile worker.

With this comes a sometimes painful role reversal. Women in the work place and two-income families are not only accepted, but close to the norm in urban areas. However, in rural areas, the situation is perceived differently. When the wife takes an off-farm job because the husband does not have a job or cannot provide sufficient income from the farm, often the result is a serious adjustment problem for the entire family.

With more mothers and fathers taking second jobs and being home less, rural America is now facing latchkey children. This is a problem with which many rural communities have never before had to deal. Another phenomenon is a teenage pregnancy rate that is rising faster than for urban areas.²³ All of these factors have led to young people wanting to leave rural

communities. With the out-migration of its youth, rural America will lose its future leadership.

While the number of elderly persons in rural areas grows, their percentage of the rural population is growing even faster because of the rapid out-migration of younger people. This is increasing the problems of the elderly in rural areas. Though they often do not have access to adequate medical care where they live, they often cannot leave their farms because of their poor or failing health. In addition, their assets and life savings are tied up in the land they own, which they are reluctant to sell because the depressed land values would not give them an adequate return. At the same time, the nuclear family has become dispersed because the younger members have scattered in order to find work. This leaves their older parents and/or grandparents in communities without emotional or financial support.





Summary Statement of the Commission

The National Action Commission on the Mental Health of Rural Americans met in early 1988 to review the two days of testimony and the data from various studies to develop pertinent recommendations. As they did, they came to several conclusions.

The commission believes that the initial step to addressing these concerns is for the nation as a whole to realize that the present problems in rural America affect not only individuals and families, but also entire communities. The troubled agricultural, mining, petroleum, lumbering and small rural manufacturing economies are undermining the economic viability and social fabric of many rural communities. This in turn further hampers individuals and families who are struggling already to cope with unprecedented economic difficulties.

Due to out-migration, many communities are losing their core of local leadership. Without leadership at the local level there will be less opportunity to revitalize rural America or break the cycle of rural poverty and debt passed from one generation to the next.

As businesses close and towns in rural America slowly become abandoned, many people who are affected move to urban areas. These are often people with few financial or vocational resources. The skills they have either are not suited for an urban environment or are not in demand. Thus, they become part of the urban population living on the fringe of existence—possibly unemployed or even homeless.²⁴

At the same time there is mounting concern about young people in rural America. Unless the issue of increased emotional problems among this group is addressed, we will certainly incur a long-term debt both intellectually and financially. The statistics cited before the commission indicate that an emotionally impaired child or adolescent is not going to reach his or her potential and that opportunity for success will be greatly diminished.

There is increased risk of early pregnancy, delinquency and other emotional problems which will increase the cost of human service programs and further strain state, county and municipal budgets. Policy makers and business executives must consider the alarming prospects of a labor force increasingly dominated by workers who grow up in poverty.

The commission formulated two premises in developing its recommendations. The first was that the time for meetings, conferences and commissions is over. The studies and data-gathering should continue, but such activities should not delay actions needed now.

The second premise was that any master plan to revitalize rural American communities must include a strong human service, health and mental health component. We cannot redevelop rural America unless we first pay attention to its social structure. A system of health, mental health, human service and education programs must be implemented to attract development, and to allow rural Americans to recover to their full potential. We must create a climate that supports the revitalization of rural America and at the same time supports a concerted effort to address human service needs.

Lastly, to whom should these recommendations be addressed? The widely held assumption that the U.S. Department of Agriculture (USDA) alone speaks for rural America is erroneous and short-sighted. Rural America is not just agriculture. If the problems facing rural America are to be successfully addressed, it will require the resources and commitment of the USDA, as well as the resources of the Department of Health and Human Services, the Department of Labor, the Department of Education and other federal agencies, plus the private sector.

This will also require an intergovernmental approach at federal, state and local levels. There should be a partnership with private industry where opportunities exist. A many-faceted network of coordination is necessary if we are to address all the needs of rural Americans and at the same time make effective and efficient use of scarce resources.





Recommendations for Action

The following recommendations are divided into five categories: Service Delivery, Funding, Public Education, Professional Education and Research.

The commission's recommendations target rural America. For this reason, it is not recommending measures such as increased insurance coverage of mental health treatment or care under public and private third-party financing that are basic to the total system of care. The commission instead chose to concentrate on the 18 courses of action that it believes will make a difference for rural America.

Service Delivery Recommendations

Recommendation 1

The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) of the U.S. Department of Health and Human Services should establish an Office of Rural Mental Health. This office's first action would be to develop and fund a National Clearinghouse and

Technical Assistance Center for Rural Mental Health.

Rationale:

The Health Resources and Services Administration (HRSA) has established an Office of Rural Health with sufficient resources to provide grant support for at least three rural health policy/research centers. The purpose of these centers is to provide an information base and a policy research capability on a wide range of concerns including access to care, financing systems and alternative delivery systems.

The commission considered recommending expansion of the mission of HRSA's Office of Rural Health along with providing additional resources commensurate to the task. However, the commission felt that unless the priority and responsibility were placed with ADAMHA, the tendency would be for ADAMHA not to assume its role and indicate that HRSA had responsibility for rural mental health issues. However, the commission believed strongly that the work of ADAMHA and HRSA should be integrated and coordinated.

A number of communities, counties and states have exemplary programs for delivering services to rural areas, and many other states and counties want to

start such programs or at least upgrade their current programs. However, no system or mechanism exists to offer consultation and technical assistance to those states and counties that want to set up such programs.

Action:

Legislation should be introduced and enacted to establish an Office of Rural Mental Health within ADAMHA and to authorize an appropriation of \$3 million to fund a Clearinghouse and Technical Assistance Center, and at least three policy research centers.

Recommendation 2

Congress should enact legislation to authorize health/mental health linkage programs that develop mental health services in community health centers and migrant health centers, or link community mental health centers with community health and migrant health centers.

Rationale:

There are approximately 1,000 community health centers in the United States, 70 percent of which are in rural areas. In 1979, the National Institute of Mental Health and the Bureau of Community Health Services participated in a program to link the work of those centers with mental health programs. The evaluation of this program found that the provision of mental health and consultation services at the Community Health Center itself was more effective than referrals to the mental health center.

In addition, there is an economic benefit to the delivery of several services in a multi-use facility. The commission believes that because of scarce resources, initiatives that make better use of such resources must be developed and encouraged. Concurrently, the linking of health and mental health treatment can help to break down the stigma associated with mental health problems.

Action:

Legislation should be introduced into Congress and enacted that authorizes \$10 million for each of five years to establish such a program. This period should be sufficient to initiate and develop such programs in a majority of rural areas served by community mental health centers and community health or migrant health centers.

Recommendation 3

The U.S. Department of Agriculture's Extension Service Program that provides crisis counseling should be expanded from its current eight states to include all states. Funding should be increased to \$12.5 million to finance this expansion.

Rationale:

P.L. 100-219, the Rural Crisis Recovery Program Act of 1987, amended Section 1440 of the 1985 Food Security Act to provide support for education, retraining and counseling assistance to financially stressed and dislocated farmers and to rural families in general. Services that can be provided through this program include "outreach counseling."

The commission welcomes the recognition by Congress and the USDA that clinical mental health services are a basic part of the rural assistance initiative. The commission also is pleased that the legislation encourages coordination between Extension Service's crisis counseling programs and state mental health systems.

The commission believes that there should be required coordination. The commission is concerned that despite the critical role played by hot lines, there must be an integrated system that links these community caregivers to the formal mental health system if their maximum potential is to be realized. Community workers can quickly become overwhelmed by the complicated nature of a serious mental illness as well as the sheer volume of those people affected. If there is not adequate linkage with the mental health system, the community worker may create a false expectation, still leaving the individual at risk.

Action:

Congress should amend the language in Section 1440 of the 1985 Food Security Act to allow all states to participate and increase the amount appropriated to \$12.5 million.



Recommendation 4

The private sector should seek opportunities to collaborate with ADAMHA to develop a partnership and provide consultation and education and prevention programs to rural America.

Rationale:

We must look for innovative ways not only to utilize existing resources, but also to break down the stigma often associated with mental health services. A number of national mental health organizations, along with Pioneer Hi-Bred International Inc. and the National Rural Health Association, have voiced their enthusiastic support for utilizing the satellite network of the National Rural Electric Cooperative Association to disseminate information about mental illnesses to rural America.

This satellite network reaches some 20 million users in rural America. The commission believes that this is an excellent opportunity for the private sector to bring a number of the excellent prevention programs that have been developed by ADAMHA, such as the Depression/Awareness, Recognition and Treatment (D/ART) program and its substance abuse programs, to a population in need of such programs.

Action:

The relevant mental health organizations, the National Rural Electric Cooperative Association and agribusinesses should initiate collaboration with ADAMHA to implement such an initiative.

Recommendation 5

State, county and local governments should specifically take into account rural areas and people in their planning, funding and regulation of mental health services.

Rationale:

Rural areas need special consideration in the design and delivery of mental health services. Rural models of care are not simply down-sized urban models. The unique needs of rural people require that special attention be given to the need for mental health services and the manner in which they are provided. Finally, service providers in rural areas may require special and/or flexible funding or regulating.

Action:

State mental health plans, regulations and reimbursement systems should have clearly identifiable accommodations to the special needs of rural areas.

Recommendation 6

State, county and local governments should require that rural development and/or rural assistance programs of any kind involve mental health experts in their planning and include attention to mental health services and service needs as part of their overall approach.

Rationale:

Evidence from efforts to respond to the legal, financial and social service needs of farmers and others in the rural crisis has consistently indicated that individuals needing such assistance are under extreme emotional stress. Emotional stress impairs an individual's ability to concentrate and make effective

decisions, both of which are necessary for taking part in financial or educational counseling, career counseling, job retraining programs, etc.

In addition, it has been noted that the emotional well-being of individuals greatly contributes to their willingness to participate in community redevelopment activities and their ability to provide leadership to such activities. Any rural recovery or revitalization effort that does not attend to the basic health and human service needs of the community is unlikely to be successful.

Action:

Any state, county or local effort/program to revitalize rural areas should have a clearly identifiable component which addresses mental health services both as a tool for economic recovery and as an end in itself.

Recommendation 7

State, county and local governments should promote the development of comprehensive, efficient and less stigmatizing approaches to rural mental health care through health and other human service agencies.

Rationale:

As the population base shrinks in rural America, attempts to maintain separate service systems with declining resources may impair the ability of these separate systems to deliver effective mental health care. A consolidation of such services would be more cost-effective and may produce other advantages at the same time. These consolidations should increase the availability and accessibility of mental health services to the rural population. Such an integration might also reduce the stigma associated with seeking mental health services and thereby increase their use.

Action:

States should initiate pilot projects which integrate mental health with other service systems in rural areas.

Recommendation 8

Elected county officials or equivalent units of government must assume the responsibility to ensure the establishment of collaborative working relationships and integration of a range of mental health, health, human service and other support services.

Rationale:

Many rural Americans who have mental health problems often have other health problems, and may also need food stamp assistance, unemployment compensation and other human services. The commission believes that only through the integration of these services and programs can complete access and availability to all needed services be ensured. Testimony before the commission underscored the need to deal with all the problems facing a person if we are to adequately treat his or her mental health problem.

Action:

The National Association of Counties, the National Association of Town and Township Executives and other similar organizations should seek appropriate avenues to encourage the coordination and integration of all human service needs in rural areas.

LOMA

A quiet, lazy Sunday afternoon
Gravel winds through brown hills
Past a pond with ice fishermen
Crosses railroad tracks
Rounds a curve into Loma
Pick-up trucks hooked to horse trailers
Stand jumbled in front of the Bar M Bar
A small horse grazes the vacant lot next door
Another one, fully saddled, is tied to a barn door
Still another, ready to go, reins looped over a horse trailer gate
In front of a gray and faded hardware store of long ago
Feet in unlaced, scuffed basketball shoes
Hang out of a half open car door
Connected to a lanky, pimpled faced kid
Whose eyes cruise an empty mainstreet
Across and down the street a man stands on hay bails
Ripping siding off an old yellow house
Other houses stand without evidence of life
Not abandoned but blank
Quiet, as if they weren't homes
Down the street
A big white church
Leaps out of dull surroundings
As if the only bright spot
In a tarnished world
Past there the gravel curves again
Quickly leaves town
Joining with the train tracks
Cuts through winter's brown prairie
Running away to the west
How long before the rest of Loma
Follows
Peter G. Beeson



Funding Recommendations

Recommendation 9

Congress, in reauthorizing the Alcohol, Drug Abuse and Mental Health Services Block Grant, should provide: 1) an equitable funding formula, 2) flexibility in administration of the provisions in the legislation, 3) a 10 percent increase in the appropriation level in FY 1990 and FY 1991 (\$50 million and \$55 million respectively).

Rationale:

The commission was distressed to learn that over the past seven years the federal resources for mental health services have been reduced by nearly one-third. Though one cannot draw a direct correlation between this decline and the loss of the mental health service capacity in rural America which the commission heard about in testimony, certainly the loss of funding has not allowed the states to meet the challenge of providing services in sparsely populated areas or to augment salaries enough to attract professionals to rural areas.

The commission believes that the states need increased flexibility in the legislation along with increased resources in order to direct available funds to

the areas of greatest need. However, with flexibility there is a corresponding need for increased accountability to ensure that additional resources reach areas of need such as rural mental health programs.

Action:

National mental health organizations should work with Congress to ensure flexibility, accountability, equitable funding and increased appropriations for the Alcohol, Drug Abuse and Mental Health Services Block Grant.

Recommendation 10

The state mental health planning process must go beyond the fragmented concentration on special populations to development of comprehensive strategies that address the service needs of all people at risk, including rural populations.

Rationale:

Current data from the NIMH Epidemiological Catchment Area Study indicate that one out of every 20 Americans needs services from the mental health delivery system. The commission believes that the state mental health planning process needs to review, evaluate and develop service delivery initiatives for the general population at risk for depression, suicide, anxiety, situational stress, alcohol abuse, etc. This planning process needs especially to take into account rural mental health systems or the need to establish such systems.

Resources can and should be made available through the State Mental Health Planning Grants, the Alcohol Drug Abuse and Mental Health Services Block Grant and a state's own resources.

Action:

State mental health plans must be state-wide, comprehensive mental health service system initiatives that deal with all people at risk of becoming disabled due to a diagnosable mental health problem.

Recommendation 11

Coverage of treatment for mental illnesses and mental health under public and private insurance programs should be on par with other illnesses and treatments.

Rationale:

Medicare and Medicaid, as currently mandated and administered, discriminate against those in need of mental health services. Concurrently, many private health insurance plans provide minimal or inadequate coverage for mental health problems. This discrimination and inadequate coverage prevent people from seeking and obtaining needed assistance and services, promotes inappropriate and unnecessary institutional care and reinforces public stigmatization of people with mental illnesses through law, regulation and practice — even though research has proven the efficacy of mental health treatment.

Community mental health agencies, unless part of a hospital, are unable to receive reimbursement for Medicare services. Many of the community mental health programs in rural areas are not part of or affiliated with a hospital, due to the demographics of rural areas. This policy not only hurts the financial viability of existing programs, but also discourages the initiation of new ones.

Action:

Congress should repeal exclusionary provisions in current law and discourage discrimination against those with mental health problems in any future legislation which finances health services.

Public Education**Recommendation 12**

Local programs must be developed to provide adequate training to general caregivers and resource people (bankers, clergy, teachers, small business people, and law enforcement officers) in recognizing and referring distressed individuals and families to appropriate services.

Rationale:

The commission felt that this was the most important recommendation with regard to the lay person in rural America. Community resource workers are the people most likely to come into contact with a distressed person or family, yet they often do not know what to do when this happens. These people are critical to breaking down the stigma of mental illnesses, because it is often to this type of person which someone with emotional distress will first tell his or her problem(s). To effectively help, these resource people must have adequate training and there must be an adequate professional mental health system to back them up.

The commission felt strongly that community mental health agencies need to assume an advocacy position in developing such a program. Concurrently, the commission felt that it was incumbent upon the private sector at the local level to fund an effective training program to ensure that its staff is prepared to fully serve its clientele.

Action:

Community resource and lay people and their employers have a responsibility to ensure that they are prepared to effectively work with their clientele. Community mental health agencies must develop and deliver required training to these people.

Recommendation 13

Staff and administrators of community mental health agencies must become active participants in the communities they serve through effective outreach strategies designed to reduce the stigma of mental health treatment and attract community members into programs and services.

Rationale:

Stigma is one of the biggest barriers to a person in a rural area who needs the help of a mental health professional. Many people are concerned about being seen going into a facility marked "mental health." The commission was impressed by the approaches to this problem offered by the programs in Wyoming and Illinois and felt that much could be accomplished if such efforts were more widespread.

Action:

The National Council of Community Mental Health Centers, the National Mental Health Association and other appropriate organizations should, through their local affiliates, encourage the use of mental health facilities for other public purposes, thereby reducing the stigma placed on mental health facilities. These organizations should also consider using other public facilities for the delivery of mental health services.

Recommendation 14

Community mental health agencies and affiliates of local Mental Health Associations should work with public school systems to enhance the schools' capacity to provide mental health information to students and provide assistance to teachers and counselors in their efforts to aid children with mental health needs.



Rationale:

One of the best places to identify and treat mental health problems among children and adolescents is within the school system. Teachers need training in early identification of emotional distress from the mental health system and moral support from the public school system if they are to effectively address the needs of a child or adolescent who has a mental health or emotional problem.

Action:

The National Mental Health Association, through its local affiliates in rural America, should seek to link rural community mental health agencies and school systems to provide information and assistance.

Professional Education**Recommendation 15**

The National Institute of Mental Health (NIMH) should increase funding for clinical training programs that focus on rural mental health human resource development, including increased funding for the State Human Resource Development Program and for faculty development programs which have rural mental health as one of their priorities.

Rationale:

The NIMH State Human Resource Development Program is directed toward states that want to upgrade their system of care or address specific needs or gaps in their delivery systems. For example, Iowa has utilized funds from this program to specifically address human resource needs in rural areas. Similar initiatives should and could be undertaken with increased resources.

The commission is concerned that, all too often, training programs for psychiatrists, psychologists, social workers, nurses and other mental health personnel do not take into account the unique characteristics of rural Americans. Clinicians coming to rural America to practice are often not prepared to serve a population that has a unique philosophy. The commission believes that NIMH needs to train mental health educators and trainers of future mental health professionals to more skillfully treat people in rural areas and to develop more sensitivity to problems unique to them. In addition, NIMH should include rural residents as a priority population in its solicitation for training grant applications.

Action:

Congress and NIMH should increase funding for the clinical training program to \$26 million, of which \$6 million would be for the State Human Resource Development Program. NIMH should include rural mental health in its requests for applications under the faculty development and stipend support programs.

Recommendation 16

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services should give priority, through its Area Health Education Centers and National Health Service Corps,

to the placement of mental health professionals in programs serving rural areas.

Rationale:

The Area Health Education Centers (AHEC) program is designed to increase the number of health practitioners in shortage areas. A portion of the training in a medical or osteopathic school is provided on-site in a medical personnel shortage area. AHECs also provide primary care residency training and multidisciplinary training and practice to physicians and other health personnel.

Action:

The Health Resources and Services Administration should expand this program and concurrently make a major effort to secure the opportunity for the training of mental health professionals and placing them in rural areas.

Recommendation 17

Community mental health agencies serving rural communities should establish formal relationships with university-based schools of psychology, social work and nursing, along with medical school departments of psychiatry for the purpose of serving as residency training sites.

Rationale:

Rural mental health programs are often inadequately staffed due to the perceived unattractiveness of a rural location. By establishing a link with a college, university or medical school training program, these areas can gain needed services and at the same time have the opportunity to attract professionals to remain in the community. These agencies should also be aware that if a mental health trainee receives federal support for his or her training, he or she has a legal obligation to re-pay that support through service in an area in need of mental health service.

Action:

The community mental health agencies in rural areas should establish formal relationships with professional training programs offering specialty training in rural service delivery.

Research**Recommendation 18**

NIMH should increase the levels of funding directed to support research on the mental health of rural Americans, such as:

- ☐ Increased efforts to obtain data on needs assessment in rural areas through biometric and epidemiological catchment area studies.
- ☐ Funding of at least two services research centers on the organization and financing of care focusing on mental health service delivery in rural America.
- ☐ Increasing funding on research on the mental health of rural children, adolescents and the elderly.

FARM HANDS

*Those creased and wrinkled hands
Thick fingers
Broad flat nails
Life lines like mine*

*I've seen them
Work a knot
Lift a bail
Plant a seed*

*They've weathered
Drought, Blizzard
Tornado, hail
Banks that fail*

*I can see them
Hooked in coveralls with pride
Stuffed in pockets with nonchalance
Clinched in anger*

*They've felt
The warmth of newborn calves
The silk of corn
The brittleness of ripened wheat*

Peter G. Beeson



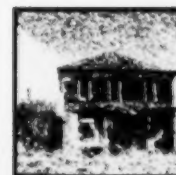
Rationale:

The commission found that despite the seriousness of mental health problems in rural America, NIMH has done few if any studies on mental illnesses in rural areas nor has it encouraged researchers to undertake such studies. Only one of the five epidemiological catchment area studies included any data on rural populations. The commission found that in 1978 the President's Commission on Mental Health noted the dearth of research and statistics on rural mental health. Unfortunately 10 years later, that situation has not improved.

The commission found the statistics on teenage suicide and depression among adolescents from the University of Minnesota made compelling arguments for significantly increasing the amount of funding in child and adolescent mental health. At the same time the demographics of the nation, particularly rural areas, demand attention to the mental health of the aging population in rural America.

Action:

Congress should direct NIMH to target a significant portion of its funds on clinical research and services research dealing with mental illnesses in rural areas, especially children, adolescents and the elderly.



Footnotes

- ¹ National Mental Health Association (1985). American dream or nightmare, unemployment and mental health in America: A report of the Commission on Mental Health and Unemployment of the National Mental Health Association. Alexandria, Virginia.
- ² Rosenberg, J. (1986). Summary report, policy forum: The personal stress problems of farmers and rural Americans. Rockville, MD: National Institute of Mental Health.
- ³ Sinclair, W. (1987). Grief is growing on farm land. Washington, D.C.: Washington Post, May 24.
- ⁴ Deavers, K. (1986). Speech given before a policy forum on rural stress. Atlanta, Georgia.
- ⁵ Sinclair, W. (1987). Grief is growing on farm land. Washington, D.C.: Washington Post, May 24.
- ⁶ Ibid
- ⁷ Ibid
- ⁸ Subcommittee on Intergovernmental Relations, Committee on Government Affairs. (1986). Governing the heartland: Can rural communities survive the farm crises? Washington, D.C.: U.S. Senate.
- ⁹ Ibid
- ¹⁰ Meeks, G., and Lawrence, S. (1988). The challenges ahead for rural America. State Legislatures, 14, No.3.
- ¹¹ Ibid
- ¹² Ibid
- ¹³ Fitch, J. M. (1987). When communities collapse: Implications for rural America. Human Services in the Rural Environment, 10, No 4; 11, No 1.
- ¹⁴ Fitch, J. M. (1981). Poverty in rural America: A case study. Boulder, Colorado: Westview Press.
- ¹⁵ Task Panel on Rural Mental Health. (1978). Report to the President from the President's Commission on Mental Health, 3.
- ¹⁶ Blazer, D. et al. (1985). Psychiatric disorders: A rural/urban comparison, Archives of General Psychiatry, 42(7).
- ¹⁷ Garfinkel, B., Hoberman, H., Parsons, J. and Walker, J. (1986). The prevalence of depression and suicide attempts in rural Minnesota youth.
- ¹⁸ Heffernan, W., and Heffernan, J. (1985). Survey of families leaving farming for financial reasons: A preliminary summary. Columbia, Missouri: University of Missouri.
- ¹⁹ Mermelstein, J. and Sundet, P. (1986). Rural community mental health centers' responses to the farm crisis. Human Services in the Rural Environment, 10, No. 1.
- ²⁰ Ellis, R. H. (1986). Survey of factors associated with admissions to mental health centers in rural and urban Colorado counties. Colorado Division of Mental Health.
- ²¹ Beeson, P. and Johnson, D. R. (1987). A panel study of change in rural mental health status: Effects of rural crisis, 1981-1986. Lincoln, Nebraska: Nebraska Department of Public Institutions and University of Nebraska.
- ²² Ahr, P. R., and Holcomb, W. R. (1985). State mental health directors' priorities for mental health care. Hospital and Community Psychiatry, 36, 39-45.
- ²³ Hannon, R. (1986). Speech before a Policy Forum: The personal stress problems of farmers and rural Americans. Chicago, Illinois.
- ²⁴ Roth, D. (1985). Homeless in Ohio: A study of people in need. Columbus, Ohio: Ohio Department of Mental Health.

Witnesses

WEST

Nedelyn Testolin
Wyoming Rural Support Network
Torrington, WY

Rev. Max Glenn
Edmond, OK

Dr. Joanne Mermelstein
University of Missouri
Columbia, MO

Dr. Paul Sundet
University of Missouri
Columbia, MO

Myrt Armstrong
North Dakota Mental Health Assoc.
Bismarck, ND

Norma Harms
Hartington, NE

Mr. Harrison Fisch
Primghar, IA

Mr. Charles Palmer
Iowa Dept. of Human Services
Des Moines, IA

Mr. Gorman L. Rasmussen
West Iowa Community Mental
Health Center
Denison, IA

EAST

Elsie Byrd
Hartsville, SC

Dr. Harry Hoberman
University of Minnesota
Medical School
Minneapolis, MN

Roger Hannan
Farm Resource Center
Cairo, IL

John Brake
Cornell University
Ithaca, NY

Mary Rolando
Tennessee Department of
Mental Health
Nashville, TN

Donald Fox, ALSW
Paducah, KY

Martha Yanchyshyon
Indian Mound, TN

Ed Callahan
Dept. of MH&MR
Austin, TX

Testimony not Presented but Submitted for the Record

John J. Gates, Ph.D.
Director
Division of Mental Health, Mental Retardation &
Substance Abuse
State of Georgia
Atlanta, GA

Kitty C. Buckwalter, R.N., Ph.D.
Director
Rural Elderly Outreach Project
Cedar Rapids, IA

Rev. Norm White
Rural Life Director
Archdiocese of Dubuque
Dubuque, IA

Joan Blundall
Director
Northwest Iowa Mental Health Center
Spencer, IA

Edgar Moles, Ph.D.
Department of Mental Health & Mental Retardation
Services
Commonwealth of Kentucky
Frankfort, KY

Albert R. Hendrix, Ph.D.
Executive Director
Department of Mental Health
State of Mississippi
Jackson, MS

Jo Ann Forsness
Hotline Coordinator
Montana W.I.F.E.
Wolf Point, MT

David Coughlin, Ph.D.
Director of Home Campus Programs
Father Flanagan's Boys' Home
Boys Town, NE

Joan R. Burney
Hartington, NE

Pamela S. Hyde
Director
Ohio Department of Mental Health
Columbus, OH

Thomas F. Updike, Ph.D.
Executive Director
Seneca Mental Health/Mental Retardation Council
Summersville, WV

Mark A. Fine, Ph.D.
Department of Psychology
University of Dayton
Dayton, OH



Bibliography

- Beeson, P., and Johnson, D. R. (1987). A panel study of change in rural mental health status: Effects of rural crisis, 1981-1986. Lincoln, Nebraska: Nebraska Department of Public Institutions.
- Department of Health and Human Services. (1988). Justification of appropriations, health resources and services administration. Rockville, Maryland.
- Fitchen, J. M. (1981). Poverty in rural America: A case study Boulder, Colorado: Westview Press.
- Fitchen, J. M. (1987). Agricultural change and rural society in the United States: Social impacts of the farm crisis.
- Garfinkel, B., Hoberman, H., Parsons, J., and Walker, J. (1986). The prevalence of depression and suicide attempts in rural Minnesota youth.
- Martinez-Browley, E. (1987). Crisis and conflict in the heartland: Social work's challenges and opportunities. Address before Annual Symposium of the National Association of Social Workers. Cedar Rapids, Iowa.
- Mermelstein, J. and Sundet, P., (1986). Rural community mental health centers' response to the farm crisis. Human Services in the Rural Environment, 10, No.1.
- Subcommittee on Intergovernmental Relations, Committee on Government Affairs. (1986). Governing the heartland : Can rural communities survive the farm crises? Washington, D.C.: U.S. Senate.
- Wagenfeld, M., and Gage, L. (1986). Mental Health services in rural areas: Origins, progress, and prospects. Las Vegas, Nevada: Annual Meeting of the American public health services in the community.



SO IT GOES

A dusting of snow
Highlights deep green winter wheat
A bow of bright yellow leaves
Frames a fading blue sky
Tall white sentinels stuffed of unwanted grain
Stand guard over rusty ribbons of steel
While bare trees cast afternoon shadows
Over faded seed and feed signs
Streets turn to gravel, then dirt
Running away into the sunset
Marking off unplowed fields
Assets of a bank gone under
Grain dust and road dirt
Share the air
With the silence of
Boarded school windows and abandoned swing sets
Homes, gray and worn
Mostly empty
Recede
Shrinking from bright red 'For Sale' signs
A tattered gray cat
Wanders from porch to porch
A left-behind mouser
Now a ghostly town crier
The church steeple's black shadow
Creeps down mainstreet
Running back to peeling white paint
And dust laden pews
Like cattle at a feed trough
Mud splattered pick-ups line the curb
Staring into dark storefronts
Empty reminders of better days and lost friends
The only sounds are the rustling of leaves on old brick streets
And the faint talk of weather drifting from the tavern
Where gray stubbled faces with weather worn eyes
Blankly search the Hamm's beer sign
Rolled up coveralls
Hover over old scuffed boots
That shift with discomfort
At the mention of foreclosure
In each other they see
Survivors or hangers on
Not sure which
They share the passing of a way of life

Peter G. Beeson

